

2009- 2010

Student  
Accident and Sickness  
Insurance Plan

*Rochester Institute of Technology*

*Underwritten by:  
Aetna Life Insurance Company  
(ALIC)  
Policy Number 812809*

## Where to Find Help

In case of an emergency, call 911, or go directly to an emergency care facility. For non-emergency situations please visit or call RIT's Student Health Services at **585-475-2255**.

### For questions about:

- \* Insurance Benefits
- \* Claims Processing
- \* Pre-Certification Requirements

Please contact:

Aetna Student Health  
P.O. Box 15708  
Boston, MA 02215-0014  
**800-466-3185**

### For questions about:

ID Cards

ID cards will be issued as soon as possible. If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

For lost ID cards, contact:

Aetna Student Health  
**800-466-3185**

### For questions about:

- \* Enrollment/Eligibility
- \* International Waiver Process

Please contact:

University Health Plans  
**800-437-6448**

### For questions about:

- \* Status of Pharmacy Claim
- \* Pharmacy Claim Forms
- \* Excluded Drugs and Pre-Authorization

Please contact:

Aetna Pharmacy Management  
**800-238-6279** (Available 24 hours)

### For questions about:

- \* Provider Listings

Please contact:

Aetna Student Health  
**800-466-3185**

A complete list of providers can be found at Aetna's **DocFind**<sup>®</sup> Service at either:  
**[www.aetna.com/docfind/custom/studenthealth/index.html](http://www.aetna.com/docfind/custom/studenthealth/index.html)** or: **[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)**

**For questions about:**

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

On Call International at **866-525-1956 (within U.S.)**

If outside the U.S., call collect by dialing **the U.S. access code** plus **603-328-1956**. Please also visit **[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)** and visit your school-specific site for further information.

**IMPORTANT NOTE**

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy issued to Rochester Institute of Technology. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits. The Master Policy may be viewed at the University's Global Risk Management Services Offices during business hours.

This student Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the customer service number on your ID card.

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Dear Students, Parents and/or Guardians:

RIT is concerned about the health, safety and general physical and mental well-being of its students. We recognize, however, that students may encounter accidents and sickness while enrolled at RIT. The RIT Student Health Center, as a primary ambulatory care facility, is available to all students when medical attention is needed. To supplement this, a direct enrollment student insurance program is available through the university. **RIT requires all students to have adequate medical insurance coverage.**

Domestic students must enroll themselves directly in the Student Accident and Sickness Insurance Plan. Enrollment must be completed by **September 30, 2009** (for students first registered in fall quarter). International students should refer to the International Student Enrollment Process.

This Brochure provides information about the health care services and programs offered by the RIT Student Health Center. These services are funded through quarterly health fees, which are separate from the charges for insurance coverage, the payment of which is required and billed automatically for all full-time undergraduate students. The health fee is also used to support other health related services and health education on campus. Part-time and graduate matriculated students may use the Student Health Center by paying the quarterly fee, or by paying a per visit fee.

This Brochure also outlines the benefits offered in the RIT Student Insurance Plans underwritten by Aetna Life Insurance Company. Page 28 has a description of an Eye Care Discount Plan that is available to RIT students enrolled in the basic medical insurance plan.

**The 2009-2010 Plans** provide substantial benefits for covered medical expenses at a reasonable cost. Coverage includes the “Basic Student Accident & Sickness Plan”, the optional “Enhanced Supplemental Medical Plan” and the “Excess Accident Plan”. Coverage is also available for a student's spouse and/or dependent children at an additional charge. At no charge to students, RIT maintains the Excess Accident Plan available to all RIT students for accidents occurring on campus or off-campus during an RIT sponsored activity.

#### **Enrollment Process**

RIT requires all students to have adequate medical insurance.

If a student does not have coverage, this requirement may be satisfied by enrolling for Basic Accident & Sickness coverage **BEFORE THE ENROLLMENT DEADLINE DATE OF SEPTEMBER 30, 2009**, or later date if appropriate. Students can enroll in this Plan by:

- Going Online at **www.universityhealthplans.com**: Students have the option to either put the charge on their RIT student account or payment can be made online with a credit card. Students first registering at RIT in the winter, spring or summer quarters must enroll within 30 days from the start of the quarter.

*Note: Graduate and part-time students may enroll voluntarily in the “Basic Student Accident & Sickness Plan”.*

#### **International Student Enrollment Process**

**ALL** international undergraduate and graduate students (full and part-time) on A, B, E, F, G, I, J, K, O, Q, R and V visas will be automatically enrolled in the Basic Accident and Sickness policy on a semi-annual basis, based on registration status. Certain foreign scholars will be eligible for exemption from the RIT required insurance enrollment and will not be billed for this coverage.

For parents of entering students, we urge you to evaluate and consider purchasing the RIT Student Accident and Sickness Insurance Plan for your student, not only based upon the absence of insurance coverage, but as an important supplement to your existing coverage as well as enhanced ease of access to services which may be needed within the larger Rochester medical community.

For Student Health Center information please contact the Student Health Center at **585-475-2255** V or **585-475-5515** TTY. For Student Accident & Sickness Insurance information contact University Health Plans at **800-437-6448**, **info@univhealthplans.com**.

Sincerely,

*E. Cassandra Jordan  
Director,  
RIT Student Health Center*

## **RIT HEALTH SERVICES**

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Access to the RIT Student Health Center is available to **all** students and does not require (or accept) the use of insurance. The SHC quarterly fee and the fee paid for the Student Accident and Sickness Insurance Plan are separate and independent of each other. While the SHC does not bill or accept payment from any insurance company, staff will provide information and/or receipts as it is capable, to assist students in submitting claims for services rendered by other providers. **RIT requires all students to have insurance coverage through either their own personal insurance carrier or through this Student Accident and Sickness Program which is made available through the university.**

### **CONFIDENTIALITY**

The Student Health Center is committed to the maintenance of confidentiality in the provider-patient relationship. The release of health care information to anyone, including parents, requires specific written authorization by the student, except as required by law or for insurance reimbursement.

### **WHAT IS THE STUDENT HEALTH CENTER?**

The Student Health Center (SHC) provides a full range of primary care, treatment and referral services, as well as related health education programs. The goal of all programs and services is to take care of students when they are ill, and assist them in learning how **TO STAY WELL**.

As a free-standing ambulatory care facility, the SHC is located in the August Center which is located between the residential and academic sides of campus. This well equipped facility provides comprehensive primary care which includes a variety of outpatient services, as well as an observation unit with three beds for use during Center hours.

### **HOW IS THE STUDENT HEALTH CENTER STAFFED?**

The SHC is staffed by physicians, nurse practitioners, nurses, health educators, administrative and support staff. The SHC providers are licensed/certified (as appropriate) in specialty areas that include Adult Medicine, Family Practice, Psychiatry, Gynecology, Health Education, Sign Language Interpreting for the Deaf, Alcohol and Other Drug Counseling. The Center also serves as a teaching site for a variety of RIT academic programs including its Physician Assistant and Nutrition Programs, clinical practicum experiences are provided for students of other colleges as well.

### **WHEN IS THE STUDENT HEALTH CENTER OPEN?**

During the fall, winter and spring quarters, the SHC is open Monday-Thursday, 8:00a.m. - 7:00p.m., Friday, 8:00a.m. - 5:00p.m. Hours of operation during academic breaks and the summer quarter are 8:00a.m. - 5:00p.m. Monday through Friday. The Center is closed during weekends and university holidays.

When the SHC is closed, campus coverage is provided through the RIT Ambulance, which is dispatched by calling Public Safety (**475-3333** V or **475-6654** TTY). This New York State certified ambulance service is staffed by well trained student volunteer emergency medical technicians who may assess medical conditions, treat and/or transport to a local hospital emergency department as the situation requires.

### **WHO CAN USE THE STUDENT HEALTH CENTER?**

The services and programs provided by the SHC are available to **all** students. Full-time undergraduate students are required to pay the quarterly health fee and are billed automatically. Part-time, graduate and co-op students may choose to pay the quarterly health fee or use the SHC on a fee-for-service basis.

### **STUDENT HEALTH FEE COVERAGE AND FINANCIAL RESPONSIBILITY**

Most of the clinical and health education services provided by the SHC are paid for by the quarterly health fee with no additional charge to the student user of the service. This includes office visits, some routine laboratory work, immunization services, minor surgery, bed observation, on-site specialty services, substance abuse counseling, HIV antibody counseling and health education programs. Diagnostic x-ray and an array of laboratory services are provided in cooperation with community based providers, many of which may be billed by the provider to the student's health insurance carrier. Charges for pharmaceuticals purchased at the SHC or off-campus, procedures referred to off-campus providers through the medical or gynecologic clinics, lab work processed at outside laboratories, tuberculin PPD tests, some serum injections, and certain specialty procedures are the responsibility of the student or parent/guardian. In addition, the cost of receiving medical care or psychiatric counseling beyond that provided by the SHC or other on-campus services including referrals to specialists, use of hospital emergency departments or hospitalization, is the responsibility of the student or parent.

## **HEALTH SERVICES AND HOW TO USE THEM**

The SHC offers five types of services: General medicine, Allergy/Immunization, Women's Health Care, Psychiatric Evaluation (ongoing mental health counseling is provided by the RIT Counseling Center in consultation and/or collaboration with the SHC psychiatrist as needed) and Health Education which includes alcohol and other drug counseling. All services are provided by appointment. Emergency appointments are accommodated as necessary.

The SHC clinical staff includes physicians, nurses and nurse practitioners who provide medical assessment, diagnosis and treatment. Referrals are made as necessary, to outside providers/facilities to ensure more comprehensive care.

### **ALLERGY/IMMUNIZATION CLINIC**

Allergy injections are administered by appointment only on a regular basis in the Allergy Clinic at no additional charge to full-time undergraduate students. Students must provide their serum, instructions and schedule from their allergist.

### **WOMEN'S HEALTH CARE CLINIC**

The Clinic is staffed by a full-time nurse practitioner with training and experience in gynecology. Comprehensive services are provided by appointment and include complete pelvic examinations, pap smears, contraceptive services, pregnancy testing and counseling, and treatment or referral as appropriate, for other gynecological problems.

### **PHYSICAL EXAMINATIONS**

Routine physical examinations are not provided by the SHC. Arrangements may be made, for physical exams, at additional cost to the student, which may be needed for co-op, internships or jobs.

### **FORMULARY SERVICES**

For the convenience of RIT students, a limited scope of prescriptive and non-prescriptive pharmaceuticals, crutches, canes and other non-returnable orthopedic soft goods may be purchased at the SHC. Only prescriptions written by a SHC physician will be accepted. Payment by Tiger Bucks, check or cash must be made at the time of service. The student may choose to use a community-based pharmacy for medication purchases.

### **LABORATORY SERVICES**

Diagnostic laboratory testing is provided as needed in support of general medical and specialty services. Most of the lab work ordered by SHC providers, including complete blood counts, mono testing, strep throat and urine cultures, cholesterol testing and glucose testing is sent to a community-based lab. The patient (or the indicated insurance company) is billed directly for this service by the laboratory.

### **RADIOLOGY**

Diagnostic x-ray services are provided by a community based radiology group. The patient is either billed directly by the radiology group for these services or provides insurance information to the provider for direct billing to the carrier. Some HMO (Health Maintenance Organization) and PPG (Preferred Provider Group) based insurance plans exclude coverage for x-rays not authorized or taken in conjunction with that HMO/PPG. While every effort will be made by SHC staff to coordinate your level of coverage with the need for diagnostic x-ray services, you should be aware of your insurance coverage requirements and limitations at the time of your visit.

### **EKG**

Electrocardiograph (EKG) diagnostic procedures are performed by staff physicians as needed. There will be an additional charge for this service if there is need to have it reviewed/read by a specialist.

### **MINOR SURGERY**

Certain minor surgical procedures are performed by SHC staff physicians. Depending upon the level of severity as determined by the provider, procedures may include suturing of lacerations, incision and drainage of abscesses, removal of small growths, and splinting or casting for minor fractures. There is no additional charge for this service for students who have paid the quarterly health fee.

## **BED OBSERVATION**

Clinical providers may house patients for illnesses requiring observation, special treatment procedures, isolation of infectious disease, and/or for injury requiring in-bed care for the duration of hours of operation. This allows students to be observed and assisted until stable or until it is determined if another source for continuing care is needed. **There is no overnight service.**

## **HEALTH EDUCATION**

Education is an integral part of the Student Health Center. Ask about formal and informal classes, counseling for personal assistance, special presentations for academic classes or campus residences, our role as an assisting resource for class assignments.

## **MEDICAL TRANSPORT SERVICES**

The SHC may assist students in arranging medical transport services when there is an acute/emergency medical need. The campus transportation department will assist patients in getting to consulting physicians or other referral locations by taxi, for which students must pay. Short-term on-campus transportation to and from class for disabling injuries may be authorized by staff providers for transport by the campus mobility van. In addition to the above, 24 hour ambulance service is available seven days a week through the RIT Ambulance Corps. The service is of no cost to students and is dispatched through Public Safety (**475-3333 V** or **475-6654 TTY**). The ambulance provides one-way transport to the emergency/urgent care facilities only. Should the RIT Ambulance not be available, another ambulance will be dispatched for which there may be a charge.

## **HOW STUDENTS ARE ACTIVE IN THE STUDENT HEALTH CENTER**

The SHC welcomes and encourages student participation in the on-going process of enhancing and maintaining the needs of students. Feedback from individual health care consumers is strongly encouraged and may be provided in whatever way is most comfortable to the consumer.

The Student Health Advisory Council (SHAC) represents all university students and exists to provide input and assistance in the planning and evaluation of services, the preparation and review of the budget and special projects of the SHC. The group is made up of representatives from various student organizations and elected bodies, as well as interested students. The SHC places great value on the work of the Council and encourages your active participation. Interested students should contact the SHC at **585-475-2255 V** or **475-5155 TTY** or **475-5850 TTY**.

## **SIGN LANGUAGE INTERPRETER**

A full-time certified interpreter is on the staff to assist with clinical interactions between the provider and the deaf/hearing impaired patient as needed.

## **MEDICAL EXCUSES FOR CLASS ABSENTEEISM**

The SHC does not issue written medical excuses. Verbal information will be made available to faculty only with the written permission of the student.

THE RIT STUDENT HEALTH CENTER IS ACCREDITED BY THE ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE, INC. (AAAHC)

## **POLICY PERIOD**

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1. **Students:** Coverage for all insured students enrolled for the Fall Semester, will become effective at 12:01a.m. on **August 15, 2009**, and will terminate at 12:01a.m. on **August 15, 2010**.
2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring Semester, will become effective at 12:01a.m. on **March 8, 2010**, and will terminate at 12:01a.m. on **August 15, 2010**.
3. **Insured dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. For more information on Termination of Covered Dependents see pages (32-33) of this Brochure. Examples include, but are not limited to: the date the student's coverage terminates, the date the dependent no longer meets the definition of a dependent.

## RATES

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Cost	Annual	Winter/Spring/Summer	Spring/Summer	Summer
	8/15/09-8/15/10	11/30/09-8/15/10	3/8/10-8/15/10	6/7/10-8/15/10
Student	\$ 780	\$ 585	\$ 390	\$ 195
Spouse	\$1,540	\$1,155	\$ 770	\$ 385
Per Child	\$1,160	\$ 870	\$ 580	\$ 290
Enhanced Supplemental Benefit	\$ 484 per person	\$ 484 per person	\$ 484 per person	\$ 484 per person

## ROCHESTER INSTITUTE OF TECHNOLOGY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

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This is a brief description of the Accident and Sickness Medical Expense benefits available for Rochester Institute of Technology students and their eligible dependents. The plan is underwritten by Aetna Life Insurance Company (called Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University's Global Risk Management Services Offices during business hours.

### STUDENT COVERAGE

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#### ELIGIBILITY

**UNDERGRADUATE STUDENTS** – as noted below (except international students). RIT requires all students to have adequate medical insurance.

If a student does not have coverage, this requirement may be satisfied by enrolling for Basic Accident & Sickness coverage **BEFORE THE ENROLLMENT DEADLINE DATE OF SEPTEMBER 30, 2009**, or later date if appropriate. Students can enroll in this Plan by either:

- Sending the Enrollment Form on the last page of this Brochure with their payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA, 02169.
- Going Online at **www.universityhealthplans.com**: Students have the option to either put the charge on their RIT student account or payment can be made online with a credit card.

Students first registering at RIT in the Winter, Spring or Summer quarters must enroll within 30 days from the start of the quarter.

#### Other comments:

1. Refer to Page 28 for enrollment method for adding Optional Supplemental Coverage.

#### 2. GRADUATE AND FULL TIME MATRICULATED EVENING DIVISION STUDENTS

Students may voluntarily enroll in this plan by sending the Enrollment Form on the last page of this Brochure with their payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA, 02169, or enrolling online at **www.universityhealthplans.com** and students have the option to either put the charge on their RIT student account or pay online with a credit card.

### 3. INTERNATIONAL STUDENTS

All matriculated, RIT international students on A, B, E, F, G, I, J, K, O, Q, R and V visas will be automatically enrolled in RIT's Basic Accident and Sickness policy.

These international students will be billed semi-annually based on their active registration status for the period (Fall/Winter and/or Spring/Summer). Coverage will terminate on **March 8, 2010** if the student is not registered during the Spring/Summer period. Students first attaining active registration status in the Winter or Summer quarters will be billed 50% of the semi-annual premium and coverage will be provided until the next semi-annual billing cycle. All other international students wishing to enroll should download and fill out the Insurance Application found at [www.universityhealthplans.com](http://www.universityhealthplans.com).

### 4. OTHER STUDENTS

ELI, SVP and foreign scholars may enroll through referral from their departments. Contact the Global Risk Management Services Office at **585-475-4903** for enrollment information.

### 5. DEPENDENT COVERAGE

Insured students may also enroll their dependents (spouse and unmarried children under age 19 residing with and supported by the Insured) in this Student Insurance Plan. To enroll your dependents, complete the Enrollment Form on the last page of this Brochure and mail with your payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA, 02169. (Refer to "Dependent Coverage" section located on page 10). You can also enroll your dependents online at [www.universityhealthplans.com](http://www.universityhealthplans.com). Payment must be made with a credit card for this option. Students must be registered and enrolled in the Basic Plan in order for dependents to be eligible for insurance coverage.

## **WAIVER PROCESS/PROCEDURE**

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### **For International Students only:**

Refer to International Student Services website for special conditions and instructions:

<http://www.rit.edu/studentaffairs/iss/forms/internationalstudentwaive.pdf>

## **REFUND POLICY**

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If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any covered dependents upon written request received by Aetna Student Health within 90 days of withdrawal from school.

## **DEPENDENT COVERAGE**

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### **ELIGIBILITY**

Covered students may also enroll their lawful spouse, and unmarried dependent children under age 19, who reside with and are fully supported by the covered student.

If this policy provides coverage for dependent children who are full-time students to a higher age than other dependent children, coverage is provided for covered dependent children who are on a certified leave of absence from school due to illness, for a period of twelve months from the last day of attendance in school. The medical necessity of a leave of absence from school must be certified by the covered dependent student's attending physician who is licensed to practice. Written documentation of the illness must be submitted to Aetna.

## **ENROLLMENT**

If an Insured adds a new dependent after the effective date of coverage, coverage will become effective for such dependent on the date the application and premium is received. An Enrollment Card and premium must be submitted within the thirty (30) day enrollment period for which the student is first enrolled. If the dependent is a newborn child and no other children are covered under the plan, notification of the birth along with the appropriate premium must be submitted within 30 days of such birth. (Addition of a spouse must be within 30 days of marital status change.)

An Enrollment Card and premium need not be submitted if the newly added dependent is a child and the Insured already has one or more covered children. However, written notice of the new child must be submitted within the 30-day period.

## **NEWBORN INFANT AND ADOPTED CHILD COVERAGE**

A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the RIT Student Accident and Sickness Plan. To extend coverage for a newborn past the 31 days, the Covered Student must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Student for 31 days from the moment of placement provided the child lives in the household of the Covered Student, and is dependent upon the Covered Student for support. To extend coverage for an adopted child past the 31 days, the Covered Student must 1) enroll the child within 31 days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

**Please note: Previously Covered Persons must re-enroll for dependent coverage by September 30, 2009 for the Fall Semester, and by March 8, 2010 for the Spring Semester, in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, a condition existing during such a break which is a Pre-Existing Condition will not be payable. See Continuously Insured Section of this Brochure.**

For information or general questions on dependent enrollment, contact University Health Plans at, **800-437-6448**.

## **CONTINUOUSLY INSURED**

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Persons who have remained continuously insured under this Policy or other policies will be covered for any Pre-Existing Condition, which manifests itself while continuously insured, except for expenses payable under prior policies in the absence of this Policy. Previously Covered Persons must re-enroll for coverage, including dependent coverage, by **September 30, 2009**, for the Fall Semester, and by **March 8, 2010**, for the Spring Semester in order to avoid a break in coverage for conditions which existed in prior policy years. Once a break in continuous coverage occurs, the Pre-Existing Conditions Limitation will apply (see page 13).

## **PREFERRED PROVIDER NETWORK**

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Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the RIT campus.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider\*. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

You may also obtain information regarding Preferred Providers by contacting Aetna Student Health at **800-466-3185**, or through the Internet by accessing DocFind at [www.aetna.com/docfind/custom/studenthealth/index.html](http://www.aetna.com/docfind/custom/studenthealth/index.html).

1. Click on “Enter DocFind”
2. Select zip code, city, or county
3. Enter criteria
4. Select Provider Category
5. Select Provider Type
6. Select Plan Type – Student Health Plans
7. Select “Start Search” or “More Options”
8. “More Options” enter criteria and “Search”

*\*Preferred providers are independent contractors and are neither employees nor agents of Aetna Life Insurance Company, Chickering Claims Administrators, Inc. or their affiliates. Neither Aetna Life Insurance Company, Chickering Claims Administrators, Inc. nor their affiliates provide medical care or treatment and they are not responsible for outcomes. The availability of a particular provider(s) cannot be guaranteed and network composition is subject to change.*

## **PRE-CERTIFICATION PROGRAM**

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Pre-certification simply means calling Aetna Student Health prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Aetna Student Health at **800-466-3185** (attention Managed Care Department).

The following inpatient services require pre-certification:

- All inpatient admissions, including length of stay, to a hospital, convalescent facility, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility
- All inpatient maternity care, after the initial 48/96 hours
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse

**Pre-Certification does not guarantee the payment of benefits for your inpatient admission.** Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the student Accident and Sickness Plan.

**Pre-Certification of Non-Emergency Inpatient Admissions, Partial Hospitalization, Identified Outpatient Services and Home Health Services:** The patient, Physician or hospital must telephone at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

**Notification of Emergency Admissions:** The patient, patient’s representative, Physician or hospital must telephone within **one (1) business day** following inpatient (or partial hospitalization) admission.

## **PRE-EXISTING CONDITIONS/ CONTINUOUSLY INSURED PROVISIONS**

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### **Pre-existing Condition**

A pre-existing condition is an injury or disease that was present before your first day of coverage under a group health insurance plan. If you received medical advice, treatment or services for that injury or disease, or you took prescription drugs or medicines for that injury or disease during the **6 months** prior to your first day of coverage, that injury or disease will be considered a pre-existing condition.

### **Limitation**

Preexisting conditions are not covered during the first **12 months** that you are covered under this plan. However, there is an important exception to this general rule if you have been Continuously Insured.

### **Continuously Insured**

You have been continuously insured if you (i) had “creditable health insurance coverage<sup>\*</sup>” (including but not limited to: COBRA, HMO, another group or individual policy, Medicare or Medicaid) prior to enrolling in this plan, and (ii) the creditable coverage ended within **63 days** of the date you enrolled under this plan. If both of these tests are met, then the pre-existing limitation period under this plan will be reduced (and possibly eliminated altogether) by the number of days of your prior creditable coverage. You will be asked to provide evidence of your prior creditable coverage. Once a break of more than **63 days** in your continuous coverage occurs, the definition of Pre-Existing Conditions will apply.

Any limitation as to a pre-existing condition will not apply in the case of a newborn enrolled within 31 days of the date of birth or a child who is adopted or placed for adoption before attaining 18 years of age and enrolled within 31 days of adoption of placement for adoption.

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<sup>\*</sup>As used above: “creditable coverage” means a person’s prior medical coverage as defined in the New York Insurance Law section 3232.

## DESCRIPTION OF BENEFITS

**Please Note: The Rochester Institute of Technology Plan may not cover all of your health care expenses. The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. Please read the RIT Student Accident and Sickness Insurance Program Plan Brochure carefully before deciding whether this Plan is right for you. While this document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. If you want to look at the full Plan description, which is contained in the Master Policy issued to RIT, you may view it at Global Risk Management Services Offices or you may contact Aetna Student Health at 800-466-3185.**

**This Plan will never pay more than \$52,000 in a Policy Year or more than \$52,000 per condition per lifetime, under the Basic Sickness Plan, \$1,500 per condition, per Policy Year for Outpatient benefits, and \$103,000 per condition per lifetime, under the Accident Plan. Additional Plan maximums may also apply. Some illnesses may cost more to treat and health care providers may bill you for what the Plan does not cover.**

Subject to the terms of the Policy, benefits are available for you and your eligible dependents only for the coverages listed below, and only up to the maximum amounts shown. Please refer to the Policy for a complete description of the benefits available.

## SUMMARY OF BENEFITS CHART

**COINSURANCE** Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable deductible, up to a maximum benefit of \$103,000 per condition, per lifetime for any one Accident, and a Maximum of \$52,000 per condition per lifetime for any one Sickness.

Basic Accident - 100% of the Negotiated Charge or the Reasonable Charge allowance (Preferred and Non-Preferred Providers respectively) for the first \$3,000 of Covered Medical Expenses, 80% thereafter.

Basic Sickness Plan - 80% of the Negotiated Charge or the Reasonable Charge allowance (Preferred and Non-Preferred Providers respectively).

**All coverage is based on Reasonable Charges unless otherwise specified.**

### Basic Accident Plan

#### Benefits - Lifetime Maximum \$103,000 per condition

	Covered Medical Expenses are payable as follows: 100% of the Negotiated Charge or the Reasonable Charge allowance (Preferred and Non-Preferred Providers respectively) for the first \$3,000 of Covered Medical Expenses, 80% thereafter. Covered Medical Expenses include (a) hospital room and board, (b) miscellaneous hospital expenses, (c) inpatient and outpatient surgery, (d) inpatient and outpatient anesthetist, (e) inpatient and outpatient Doctor visits, (f) consultant, (g) licensed nurse, (h) hospital outpatient department, (i) emergency room, (j) diagnostic x-ray and lab tests, (k) outpatient prescription drug, (l) ambulance, (m) durable medical equipment, and (n) other expenses incurred for the treatment of an Injury.
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### Basic Sickness Plan

#### Benefits - Lifetime Maximum \$52,000 per condition

#### Inpatient Hospitalization Benefits

Hospital Room and Board Expense	<b>Covered Medical Expenses</b> are payable as follows: <u>Preferred Care</u> : 80% of the Negotiated Charge. <u>Non-Preferred Care</u> : 80% of the Reasonable Charge for a semi-private room.
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Intensive Care Unit Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge for the Intensive Care Room Rate for an overnight stay.</p>
Miscellaneous Hospital Expense	<p><b>Covered Medical Expenses</b> include, but are not limited to: laboratory tests, x-rays, surgical dressings, anesthesia, supplies and equipment use, and medicines. Benefits are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.</p>
Physician Hospital Visit/ Consultation Expenses	<p><b>Covered Medical Expenses</b> for charges for the non-surgical services of the attending Physician, or a consulting Physician, are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.</p>
<b>Surgical Benefits (Inpatient and Outpatient)</b>	
Surgical Expense	<p><b>Covered Medical Expenses</b> for charges for surgical services, performed by a Physician, are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.</p> <p>Outpatient benefits are limited to \$1,500 per condition, per Policy Year.</p>
Anesthetist and Assistant Surgeon Expense	<p><b>Covered Medical Expenses</b> for the charges of an anesthetist and an assistant surgeon, during a surgical procedure, are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.</p>
Ambulatory Surgical Expense	<p><b>Covered Medical Expenses</b> for outpatient surgery performed in an ambulatory surgical center are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge  <b>Covered Medical Expenses</b> must be incurred on the day of the surgery or within 48 hours after the surgery.</p>
<b>Outpatient Benefits</b>	
<p><b>Covered Medical Expenses</b> include but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab, or radiological facility.</p>	
Emergency Room Expense	<p><b>Covered Medical Expenses</b> incurred for treatment of an Emergency Medical Condition are payable as follows:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>

Urgent Care Expense	<p><i>Benefits include charges for treatment by an urgent care provider.</i></p> <p><b>Please note: A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition, is an emergency condition. The covered person should go directly to the emergency room of a hospital or call 911 (or the local equivalent) for ambulance and medical assistance.</b></p> <p><b>Urgent Care</b> Benefits include charges for an urgent care provider to evaluate and treat an urgent condition.</p> <p><b>Covered Medical Expenses</b> for urgent care treatment are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><i>No benefit will be paid under any other part of this Plan for charges made by an urgent care provider to treat a non-urgent condition.</i></p> <p>Non-urgent care includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> <li>• routine or preventive care (this includes immunizations),</li> <li>• follow-up care,</li> <li>• physical therapy,</li> <li>• elective surgical procedures, and</li> <li>• any lab and radiologic exams which are not related to the treatment of the urgent condition.</li> </ul>
Ambulance Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  100% of the Reasonable Charge for the services of a professional ambulance to or from a hospital, when required due to the emergency nature of a covered Accident or Sickness.</p>
Pre-Admission Testing Expense	<p><b>Covered Medical Expenses</b> for Pre-Admission testing charges while an outpatient before scheduled surgery are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>
Physician's Office Visits	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to 10 visits per condition, per Policy Year and \$65 per visit.</p>
Laboratory and X-Ray Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>

Chemotherapy Expense	<p><b>Covered Medical Expenses</b> for chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, radiation therapy, tests and procedures, physiotherapy (for rehabilitation only after a surgery), and expenses incurred at a radiological facility.</p> <p><b>Covered Medical Expenses</b> also include expenses for the administration of chemotherapy and visits by a health care professional to administer the chemotherapy.</p> <p>Such expenses are payable as follows:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>
Durable Medical Equipment Expense	<p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>
Prosthetic Devices Expense	<p>Benefits include charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of an accident or sickness.</p> <p><b>Covered Medical Expenses</b> do <b>not</b> include: eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  Payable as any other Sickness.</p>
Outpatient Physical Therapy Expense	<p><b>Covered Medical Expenses</b> for physical therapy are payable as follows when provided by a licensed physical therapist and only when physical therapy begins within 6 months of the onset of symptoms:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to 10 visits per condition, per Policy Year, and \$65 per visit</p>

<p>Dental Injury Expense</p>	<p><b>Covered Medical Expenses</b> include dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition:</p> <ul style="list-style-type: none"> <li>• Natural teeth damaged, lost, or removed, or</li> <li>• Other body tissues of the mouth fractured or cut due to injury. The accident causing the injury must occur while the person is covered under this Plan.</li> </ul> <p>Any such teeth must have been:</p> <ul style="list-style-type: none"> <li>• Free from decay, or</li> <li>• In good repair, and</li> <li>• Firmly attached to the jawbone at the time of the injury</li> </ul> <p><i>The treatment must be done in the calendar year of the accident or the next one.</i></p> <p>If:</p> <ul style="list-style-type: none"> <li>• Crowns (caps), or</li> <li>• Dentures (false teeth), or</li> <li>• Bridgework, or</li> <li>• In-mouth appliances</li> </ul> <p>are installed due to such injury, <b>Covered Medical Expenses</b> include only charges for:</p> <ul style="list-style-type: none"> <li>• The first denture or fixed bridgework to replace lost teeth,</li> <li>• The first crown needed to repair each damaged tooth, and</li> <li>• An in-mouth appliance used in the first course of orthodontic treatment after the injury</li> </ul> <p>Surgery needed to:</p> <ul style="list-style-type: none"> <li>• Treat a fracture, dislocation, or wound</li> <li>• Cut out cysts, tumors, or other diseased tissues</li> <li>• Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement</li> </ul> <p>Non-surgical treatment of infections or diseases. This does not include those of, or related to, the teeth.</p> <p><b>Covered Medical Expenses</b> are payable as follows: 100% of Actual Charge up to \$3,000 and 80% thereafter.</p>
<p>Impacted Wisdom Teeth Expense</p>	<p><b>Covered Medical Expenses</b> for removal of one or more impacted wisdom teeth are payable as follows:</p> <p><u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to \$100 per tooth.</p>
<p>Allergy Testing Expense</p>	<p>Benefits include charges incurred for diagnostic testing of allergies.</p> <p><b>Covered Medical Expenses</b> include, but are not limited to, charges for the following:</p> <ul style="list-style-type: none"> <li>• laboratory tests,</li> <li>• physician office visits, including visits to administer injections,</li> <li>• prescribed medications for testing of the allergy, including any equipment used in the administration of prescribed medication, and</li> <li>• other medically necessary supplies and services</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:</p> <p><u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to 10 visits per condition, per Policy Year, and \$65 per visit.</p>

<p>Diagnostic Testing for Attention Disorders and Learning Disabilities Expense</p>	<p><b>Covered Medical Expenses</b> for diagnostic testing for:</p> <ul style="list-style-type: none"> <li>• Attention Deficit Disorder, or</li> <li>• Attention Deficit Hyperactive Disorder, or</li> <li>• Dyslexia</li> </ul> <p>are payable as follows:  <u>Preferred Care:</u> 80% of the Negotiated Charge.  <u>Non-Preferred Care:</u> 80% of the Reasonable Charge.</p> <p>Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Policy.</p> <p>Benefits are limited to \$2,000 per Policy Year.</p>
<p>Musculoskeletal/Chiropractic Therapy Expense</p>	<p><b>Covered Medical Expenses</b> include charges for Musculoskeletal Therapy provided on an outpatient basis.</p> <p>For purposes of this benefit, “Musculoskeletal Therapy” means the diagnosis, and treatment, by manual or mechanical means, of the musculoskeletal structure, due to lack of normal nerve, muscle, and /or joint function, following an injury.</p> <p>Benefits for chiropractic care will be paid on the same basis as those payable for care or services provided by other health professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments.</p>
<p>Well Baby Care Expense</p>	<p>Benefits include charges for routine preventive and primary care services, rendered to a covered dependent child on an outpatient basis.</p> <p><b>Routine preventive and primary care</b> services are services rendered to a covered dependent child, from the date of birth through the attainment of <b>two (2)</b> years of age. Services include: initial hospital check-ups, other hospital visits, physical examinations, including routine hearing and vision examinations, medical history, developmental assessments, and materials for the administration of appropriate and necessary immunizations and laboratory tests, when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics.</p> <p><b>Benefits for materials for the administration of immunizations</b> are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Coverage for such services shall be provided only to the extent that such services are provided by, or under the supervision of a physician, or other licensed professional.</p> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care:</u> 100%, of the Negotiated Charge for the first \$2,000 of Medical Expenses, 80% thereafter subject to a maximum of \$65 per visit. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics, or</p> <ul style="list-style-type: none"> <li>• Same as any other accident of sickness, subject to a maximum of \$65 per visit.</li> </ul> <p><u>Non-Preferred Care:</u></p> <ul style="list-style-type: none"> <li>• 100%, of the Negotiated Charge for the first \$2,000 of Medical Expenses, 80% thereafter</li> <li>• subject to a maximum of \$65 per visit. Benefits are payable for scheduled visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics, or</li> <li>• same as any other accident of sickness, subject to a maximum of \$65 per visit.</li> </ul>
<p>Consultant or Specialist Expense</p>	<p><b>Covered Medical Expenses</b> include the expenses for the services of a consultant or specialist. The services must be requested by the attending physician for the purpose of confirming or determining to confirm or determine a diagnosis.</p> <p>Benefits are payable as follows:  <u>Preferred Care:</u> 100% of the Negotiated Charge.  <u>Non-Preferred Care:</u> 100% of the Reasonable Charge.</p> <p>Benefits are limited to \$125 per condition, per Policy Year.</p>

**Treatment of Mental and Nervous Disorders**

Biologically Based Mental Illness and for Children with Serious Emotional Disturbances

“Biologically Based Mental Illness” means a mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive-compulsive disorder, bulimia and anorexia.

“Children with Serious Emotional Disturbances” means: persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- Serious suicidal symptoms or other life-threatening self-destructive behaviors,
- Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors),
- Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage, or
- Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

**Inpatient**

**Covered Medical Expenses** include expenses incurred by a **covered person** while confined as a full-time inpatient in a **hospital** or **residential treatment facility** for the treatment of Biologically Based Mental Illness or Children with Serious Emotional Disturbances.

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 80% of the Reasonable Charge.

*Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization or intensive outpatient treatment may be exchanged for 1 day of full hospitalization.*

**Outpatient**

**Covered Medical Expenses** include expenses while a **covered person** is not confined as a full-time inpatient in a **hospital**, for the treatment of Biologically based Mental Illness or Children with Serious Emotional Disturbances.

Preferred Care: 80% of the Negotiated Charge.

Non-Preferred Care: 80% of the Reasonable Charge.

Outpatient treatment is covered up to a maximum of 20 visits per Policy Year.

**Not Covered are Charges for Services:**

- While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth.
- Provided solely because such services are ordered by a court.
- Deemed to be cosmetic in nature.

<p>Other than Biologically Based Mental Illness and Children with Serious Emotional Disturbances</p>	<p><b>Inpatient Benefits</b>  <b>Covered Medical Expenses</b> include expenses incurred by a <b>covered person</b> while confined as a full-time inpatient in a <b>hospital</b> or <b>residential treatment facility</b> for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances.  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.  Inpatient benefits are payable up to a maximum of 30 days per Policy Year.  <i>Includes the charges made for treatment received during partial hospitalization or intensive outpatient in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization or intensive outpatient treatment may be exchanged for 1 day of full hospitalization.</i></p> <p><b>Outpatient Treatment</b>  <b>Covered Medical Expenses</b> include expenses while a <b>covered person</b> is not confined as a full-time inpatient in a <b>hospital</b>, for the treatment of Mental Illness other than Biologically based Mental Illness or Children with Serious Emotional Disturbances.  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.  Outpatient treatment is covered up to a maximum of 20 visits per Policy Year.  <b>Not Covered are Charges for Services:</b></p> <ul style="list-style-type: none"> <li>• While incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth.</li> <li>• Provided solely because such services are ordered by a court.</li> <li>• Deemed to be cosmetic in nature.</li> </ul>
<p><b>Substance Abuse Benefits</b></p>	
<p>Inpatient Expense</p>	<p><b>Covered Medical Expenses</b> include the treatment of a substance abuse condition while confined as an inpatient in a hospital or facility licensed for such treatment.  <b>Covered Medical Expenses</b> also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization.  Benefits are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.  Benefits will include 7 inpatient days for detoxification in any calendar year and 30 inpatient days for rehabilitation in any calendar year.</p>
<p>Outpatient Expense</p>	<p><b>Covered Medical Expenses</b> for outpatient diagnosis and treatment of a substance abuse condition are payable as follows:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  Benefits are limited to 60 visits per Policy Year, 20 of which may be used for family counseling.</p>

<b>Maternity Benefits</b>	
Maternity Expense	<p><b>Covered Medical Expenses</b> include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>Any decision to shorten such minimum coverages shall be made by the attending Physician, in consultation with the mother. In such cases, <b>covered medical expenses</b> may include at least one home care visit. This home care visit may be requested at any time within 48 hours of the time of a vaginal delivery, or within 96 hours of a delivery, and shall be delivered within 24 hours after discharge, or 24 hours of the mother’s request, whichever is later.</p> <p>The home care visit will not be subject to any deductible, copay or insurance.</p> <p><b>Covered Medical Expenses</b> for maternity care also include:</p> <ul style="list-style-type: none"> <li>• Parent education</li> <li>• Assistance and training in breast or bottle feeding and,</li> <li>• The performance of any necessary maternal and newborn clinical assessments</li> </ul> <p><b>Covered Medical Expenses</b> for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness.</p> <p><b>Covered Medical Expenses</b> include services of a licensed midwife unless those services duplicate the services already provided by the covered person’s physician.</p> <p>During the initial 48 or 96 hours, no pre-certification is required for the mother, or her newly born child. Pre-certification is required, after the 48, or 96 hours.</p>
Well Newborn Nursery Care Expense	<p>Benefits include charges for routine care of a covered person’s newborn child as follows:</p> <ul style="list-style-type: none"> <li>• hospital charges for routine nursery care during the mother’s confinement, but for not more than four days for a normal delivery,</li> <li>• physician’s charges for circumcision, and</li> <li>• physician’s charges for visits to the newborn child in the hospital and consultations, but for not more than 1 visit per day</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.</p>
<b>Additional Benefits</b>	
Prescription Drug Benefit	<p>Prescription Drug Benefits are payable as follows:  <u>Preferred Care Pharmacy</u>: 100% of the Negotiated Charge following a \$1 Copay for each Brand Name Prescription Drug or a \$1 Copay for each Generic Prescription Drug.  <u>Non-Preferred Care Pharmacy</u>: 100% of the Reasonable Charge following a \$1 Copay for each Brand Name Prescription Drug or a \$1 Copay for each Generic Prescription Drug.</p> <p>Covered Medical Expenses are payable up to a maximum of \$500 per Policy Year. Refer to page 50 for Prescription Drug Claim Procedure.</p>
Diabetic Treatment and Supplies Expenses	<p><b>Covered Medical Expenses</b> include expenses incurred in connection with the treatment of diabetes, including diabetic testing supplies and equipment, including:</p> <p>Blood glucose monitors (including monitors for the legally blind), data management systems, test strips, insulin injecting aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances, insulin infusion devices and oral agents for controlling blood sugar.</p> <p>Benefits are payable as any Sickness.</p>

Diabetic Self-Management Education Expense	<p><b>Covered Medical Expenses</b> will include training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. Such education may be provided in a group setting, and when medically necessary, diabetic self-management education shall also include home visits.</p> <p><i>Please see definition of Diabetic Self-Management Education on page 39 for more detailed information on this benefit.</i></p> <p>Benefits for Self-Management Education and Home Health Care are payable as any Sickness.</p>
Non Prescription Enteral Formula Expense	<p>Benefits include charges incurred by a covered person for non-prescription enteral formulas, for which a physician has issued a written order, and are for the treatment of malabsorption caused by:</p> <ul style="list-style-type: none"> <li>• Crohn’s Disease,</li> <li>• ulcerative colitis,</li> <li>• gastroesophageal reflux,</li> <li>• gastrointestinal motility,</li> <li>• chronic intestinal pseudoobstruction, and</li> <li>• inherited diseases of amino acids and organic acids</li> </ul> <p><b>Covered Medical Expenses</b> for inherited diseases of amino acids and organic acids, will also include food products modified to be low protein.</p> <p><b>Covered Medical Expenses</b> are payable as follows: Payable as any other sickness. Modified solid food products (MFSP) that are low in protein are covered up to the maximum of \$2,500 per Covered Person, per Policy Year.</p>
Temporo-mandibular Joint Dysfunction (TMJ)	<p><b>Covered Medical Expenses</b> include charges incurred, by a <b>covered person</b>, for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction, when the TMJ disorder is medical in origin. Benefits are payable on the same basis, as any other sickness.</p>
Prescription Contraceptive Drugs and Devices	<p><b>Covered Medical Expenses</b> include:</p> <ul style="list-style-type: none"> <li>• Charges incurred for contraceptive drugs and devices that by law need a physician’s prescription and that have been approved by the FDA.</li> <li>• Related outpatient contraceptive services such as: <ul style="list-style-type: none"> <li>• Consultations,</li> <li>• Exams,</li> <li>• Procedures, and</li> <li>• Other medical services and supplies</li> </ul> </li> </ul> <p>Benefits are payable as any sickness.</p>
Pap Smear Expense	<p><b>Covered Medical Expenses</b> include one annual routine pap smear screening for women age 18 and older.</p> <p>Benefits are payable as any Sickness.</p> <p>A referral is not required for this benefit.</p>

Mammography Expense	<p><b>Covered Medical Expenses</b> include one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are:</p> <ul style="list-style-type: none"> <li>• Prior personal history of breast cancer</li> <li>• Positive Genetic Testings</li> <li>• Family history of breast cancer, or</li> <li>• Other risk factors</li> </ul> <p>Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.</p> <p>Benefits are payable as any Sickness.</p> <p>A referral is not required for this benefit.</p>
Mastectomy Reconstruction Benefit	<p><b>Covered Medical Expenses</b> will include expenses incurred for:</p> <ul style="list-style-type: none"> <li>• all stages of reconstruction of the breast on which a mastectomy has been performed, and</li> <li>• surgery and reconstruction of the other breast to produce a symmetrical appearance.</li> </ul> <p>Benefits are payable as any Sickness.</p> <p>A referral is not required for this benefit.</p>
Elective Abortion Expenses	<p>If, as a result of pregnancy having its inception during the Policy Year, a covered person incurs expenses in connection with an elective abortion, a benefit is payable.</p> <p><b>Covered Medical Expenses</b> for Elective Abortion Expense are covered as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>There is a benefit maximum of \$250 per Policy Year.</u></p> <p>This benefit is in lieu of any other Policy benefits.</p>
Chlamydia Screening Test Expense	<p><b>Covered Medical Expenses</b> include charges incurred for an annual Chlamydia screening test. Benefits will be paid for Chlamydia screening expenses incurred for:</p> <ul style="list-style-type: none"> <li>• Women who are: <ul style="list-style-type: none"> <li>• under the age of 20 if they are sexually active, and</li> <li>• at least 20 years old if they have multiple risk factors</li> </ul> </li> <li>• Men who have multiple risk factors</li> </ul> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>
Routine Screening for Sexually Transmitted Disease Expense	<p><b>Covered Medical Expenses</b> include charges for covered persons who are at least 18 years old and who are sexually active for annual routine screening for sexually transmitted diseases.</p> <p>Benefits are payable as follows:</p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>

<p>Routine Prostate Cancer Screening Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred for the screening of cancer, as follows:</p> <ul style="list-style-type: none"> <li>• For a male age 40 and over, with a family history of prostate cancer or other prostate cancer risk factors, Standard Diagnostic Testing once each Policy Year.</li> <li>• For a male age 50 or over who is asymptomatic, Standard Diagnostic Testing once each Policy Year.</li> </ul> <p>For a male, any age, with a prior history of prostate cancer, Standard Diagnostic Testing as recommended, by the covered person’s physician.</p> <p>Standard Diagnostic Testing includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• a digital rectal examination, and</li> <li>• a prostate-specific antigen test</li> </ul> <p>Benefits are payable as any Sickness.</p>
<p>Second Opinion for Cancer Treatment Expense</p>	<p><b>Covered Medical Expenses</b> include a second opinion consultation by a specialist for the diagnosis or recommended treatment of cancer. The specialist must be board certified in the medical field relating to the diagnosis.</p> <p>Coverage will also be provided for any expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>If the covered person does not obtain a referral from a <u>Preferred Care</u> provider for <u>Non-Preferred Care</u>, the level of coinsurance for <u>Non-Preferred Care</u> may be reduced. With a referral, benefits will be payable at the same level for a <u>Non-Preferred Care</u> as it would be for <u>Preferred Care</u>.</p> <p>Benefits are payable as any Sickness.</p>
<p>Surgical Second Opinion Expense</p>	<p><b>Covered Medical Expenses</b> will include expenses incurred for a second opinion consultation by a specialist on the need for surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required x-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to 10 visits per condition, per Policy Year, or and \$65 per visit.</p>
<p>Elective Surgical Second Opinion Expense</p>	<p><b>Covered Medical Expenses</b> will include expenses incurred for a second opinion consultation by a specialist on the need for non-emergency elective surgery which has been recommended by the covered person’s physician. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Coverage will also be provided for any expenses incurred for required x-rays and diagnostic tests done in connection with that consultation. Aetna must receive a written report on the second opinion consultation.</p> <p>Benefits are payable as follows:  <u>Preferred Care</u>: 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.  <u>Non-Preferred Care</u>: 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to 10 visits per condition, per Policy Year, or and \$65 per visit.</p>

<p>Acupuncture in Lieu of Anesthesia Expense</p>	<p><b>Covered Medical Expenses</b> include acupuncture therapy, when acupuncture is used in lieu of other anesthesia, for a surgical or dental procedure covered under this Plan.</p> <p>The acupuncture must be administered by a health care provider who is a legally qualified physician, practicing within the scope of their license.</p> <p><u>Preferred Care:</u> 80% of the Negotiated Charge.</p> <p><u>Non-Preferred Care:</u> 80% of the Reasonable Charge.</p> <p>Outpatient benefits are limited to the \$1,500 per condition, per Policy Year outpatient surgical maximum.</p>
<p>Dermatological Expense</p>	<p><b>Covered Medical Expenses</b> include charges for the diagnosis and treatment of skin disorders, ex laboratory fees. Related laboratory expenses are covered under the Outpatient Expense Benefit.</p> <p>Benefits are payable as any other Sickness.</p> <p><i>Covered Medical Expenses do not include treatment for acne, or cosmetic treatment and procedures.</i></p>
<p>Podiatric Expense</p>	<p><b>Covered Medical Expenses</b> include charges for podiatric services, provided on an outpatient basis following an injury.</p> <p>Benefits are payable as follows: Payable as any other sickness.</p> <p>Expenses for routine foot care, such as trimming of corns, calluses, and nails, are <b>not Covered Medical Expenses</b>.</p>
<p>Home Health Care/Services Expenses</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for home health care services made by a home health agency pursuant to a home health care plan.</p> <p><i>Please see definitions on page 40 for more detailed information on this benefit.</i></p> <p><u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p><u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p> <p>Benefits are limited to 40 visits per policy year incurred within 12 months of the initial visit.</p>
<p>Transfusion or Dialysis of Blood Expense</p>	<p><b>Covered Medical Expenses</b> include charges for the transfusion or dialysis of blood, including the cost of: whole blood, blood components, and the administration thereof.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter. <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter.</p>
<p>Hospice Benefit</p>	<p><b>Covered Medical Expenses</b> include charges for hospice care provided for a terminally ill covered person during a hospice benefit period, including acute care services at an acute care facility.</p> <p>Benefits are payable as follows: <u>Preferred Care:</u> 100% of the Negotiated Charge for the first \$2,000 of Medical Expenses: 80% thereafter <u>Non-Preferred Care:</u> 100% of the Reasonable Charge for the first \$2,000 of Medical Expenses: 80% thereafter</p> <p><i>Please see definition on page 40 for more information on Hospice Care Expenses. Benefits for Hospice expenses require pre-certification.</i></p>

<p>Licensed Nurse Expense</p>	<p>Benefits include charges incurred by a covered person who is confined in a hospital as a resident bed-patient, and requires the services of a registered nurse or licensed practical nurse.</p> <p><b>Covered Expenses</b> for a Licensed Nurse are covered as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge.</p>
<p>Skilled Nursing Facility Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for confinement in a skilled nursing facility for treatment rendered:</p> <ul style="list-style-type: none"> <li>• in lieu of confinement in a hospital as a full time inpatient, or</li> <li>• within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement</li> </ul> <p><b>Covered Medical Expenses</b> are payable as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge for the semi-private room rate.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge for the semi-private room rate.</p> <p><i><b>Benefits for Skilled Nursing require pre-certification.</b></i></p>
<p>Rehabilitation Facility Expense</p>	<p><b>Covered Medical Expenses</b> include charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility. Confinement in the rehabilitation facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of hospital or skilled nursing facility confinement.</p> <p><b>Covered Medical Expenses</b> for Rehabilitation Facility Expense are covered as follows:  <u>Preferred Care</u>: 80% of the Negotiated Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.  <u>Non-Preferred Care</u>: 80% of the Reasonable Charge for the rehabilitation facility’s daily room and board maximum for semi-private accommodations.</p> <p><i><b>Benefits for Rehabilitation Facility expenses require pre-certification.</b></i></p>
<p>Bone Density Screening Expense</p>	<p><b>Covered Medical Expenses</b> include bone mineral density measurements or tests. Benefits will be paid for expenses incurred by a covered person for a bone density screening upon the recommendation of the covered person’s physician for:</p> <ol style="list-style-type: none"> <li>1) an individual previously diagnosed as having osteoporosis or having a family history of osteoporosis, or</li> <li>2) an individual with symptoms or conditions indicative of the presence, or the significant risk of osteoporosis, or</li> <li>3) an individual on a prescribed drug regimen posing a significant risk of osteoporosis, or</li> <li>4) an individual with lifestyle factors to such a degree as posing a significant risk of osteoporosis, or</li> <li>5) with such age, gender, and/or physiological characteristics which pose a significant risk for osteoporosis</li> </ol> <p>Benefits are payable as any Sickness.</p>

### **Supplemental Medical Coverage**

An Enhanced Supplemental Plan is available for an additional cost, subject to the following enrollment conditions. Please note that mental health services are not eligible for coverage under this Supplemental Plan. When this optional Supplemental Plan is purchased, Covered Medical Expenses incurred for an Injury or Sickness while insured and in excess of the \$103,000 for any one Accident and in excess of \$52,000 for any one Sickness, will be payable at 100% up to a maximum lifetime benefit of \$250,000 for any one covered Accident or any one covered Sickness.

Covered Medical Expenses include (a) hospital room and board, (b) miscellaneous hospital expenses, (c) inpatient and outpatient surgery, (d) inpatient and outpatient anesthetist, (e) inpatient and outpatient Doctor visits, (f) consultant, (g) licensed nurse, (h) hospital outpatient department, (I) emergency room, (j) diagnostic x-ray and lab tests, (k) outpatient prescription drug, (l) ambulance, (m) durable medical equipment, and (n) other expenses incurred for the care and treatment of an Injury or Sickness, subject to the exclusions and limitations of the Plan.

Only students and dependents insured for the Basic Accident and Sickness Plan may purchase this Enhanced Supplemental Plan. The Supplemental Plan must be purchased by **September 30, 2009** for the Fall Quarter, or within 30 days after the start of the quarter in which the student is first enrolled in the Basic Plan for the academic year. Students and Dependents must enroll in the Basic Accident and Sickness Plan in order to be eligible for the Optional Supplemental Plan. The Optional Supplemental Plan must be purchased at the same time as enrollment under the Basic Plan.

*Note: To purchase this optional coverage, students will need to download and submit an Enrollment Form, found at [www.universityhealthplans.com](http://www.universityhealthplans.com), and include premium payment. Students who purchase the Enhanced Supplemental Plan must also enroll any eligible dependents who are insured under the Basic Plan. Dependents may not be enrolled for this Enhanced Supplemental Plan without the student being enrolled or without being insured under the Basic Plan.*

## **EXCESS ACCIDENT PLAN**

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RIT maintains an Excess Accident Plan, at no charge, for all RIT students. This Excess Accident Plan provides up to \$10,000 of coverage in full at the Negotiated Charge or Reasonable Charge (Preferred and Non-Preferred Providers respectively) for accidents occurring on campus or occurring off-campus at an RIT sponsored activity. (Accidental Death and Dismemberment Benefit provided by underwritten by United States Fire Insurance Company, USFIC.)

Expenses incurred for injuries resulting from the play or practice of intercollegiate sports is limited to \$1,000. (This does not include Intramural or Club Sports.) All other primary medical insurance benefits must be first paid prior to this Excess Accident Plan's benefits being paid. If the student is enrolled under the RIT Basic Student Accident and Sickness Insurance Plan, that Plan is considered primary coverage. Any accident claims submitted under the Basic Plan will automatically be submitted to the Excess Accident Plan if all accident expenses have not been covered under the Basic Plan and the accident meets the definition of a covered accident under this Plan. Claim Forms for students not enrolled in the RIT Basic Plan can be obtained by calling the Risk Management and Safety Services Office at **(585) 475-4903**.

## **ADDITIONAL SERVICES AND DISCOUNTS**

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As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna. To learn more about these additional services and search for providers visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

**Aetna Vision<sup>SM</sup> Discount Program:** The Aetna Vision discount program helps you save on vision exams and many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).

**Aetna Fitness<sup>SM</sup> Discount Program:** Aetna's Fitness discount program provides members with access to preferred membership rates at nearly 10,000 fitness clubs nationwide and in Canada in the GlobalFit<sup>TM</sup> network. Members can also save on GlobalFit's other programs and services, such as at-home weight loss programs, home fitness equipment and videos and even one-on-one health coaching services\* to help them quit smoking, reduce stress, lose weight, or meet any other health goal.

*\* Offered by WellCall, Inc. through GlobalFit*

**Aetna Weight Management<sup>SM</sup> Discount Program:** Helps you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides members and their eligible family members access to discounts on Jenny Craig<sup>®</sup> weight loss programs and products. Start with a FREE 30-day trial membership\* then choose either a 6\*-or 12\*-month program\*\* that's right for you. You also receive individual weight loss consultations, personalized menu planning, tailored activity planning, motivational materials and much more.

*\* Offers good at participating centers in the United States, Canada and Puerto Rico and through Jenny Direct at-home. Additional cost for all food purchases and shipping where applicable.*

*\*\* Additional weekly food discounts will grow throughout the year, based on active participation.*

**Find a meal plan that works for you at eDiets<sup>®</sup>:** Get a personalized plan for healthy eating that fits your lifestyle, and save 25 percent on weekly eDiets dues. You'll have access to customized weekly menus, recipes, support boards, chats, nutrition tools and fitness tips.

**Use Zagat<sup>®</sup> reviews as a guide for your night out:** Planning a night on the town? Or, want to visit a city where you've never been? Subscribe to Zagat online and get a 30 percent discount on their members-only services. You can sign up for access to restaurant reviews only, or choose full access and get ratings and reviews on hotels, restaurants, movies and other attractions. You can even order printed guides at a discount!

**Give the gift of relaxation to yourself or a friend through SpaWish:** Get a 10 percent discount when you buy a gift certificate of at least \$100, good for services at any of over 1,000 spas across the U.S. Choose a spa close to home or near your favorite place to visit!

**Get trusted health information from the MayoClinic.com Bookstore:** Choose from newsletters and books with recipes for healthy living, advice on staying in shape, guides on living with certain health conditions and more. It's all at your fingertips - and at a discount! The size of the discount will depend on the item price and other available discounts.

**Aetna's Informed Health<sup>®</sup> Line:** Get answers from a registered nurse at any time - just call our toll-free Informed Health Line. With one simple call, you can:

- Learn more about health conditions that you or your family members have
- Find out more about a medical test or procedure
- Come up with questions to ask your doctor

**Talk to a registered nurse:** Our nurses can discuss more than 5,000 health and wellness topics. Call them anytime you have a health question.

**Listen to our Audio Health Library<sup>\*</sup>:** Call and learn about a topic that interests you. Choose from thousands of health conditions. Listen in English or Spanish. You can also transfer to a registered nurse at any time during your call.

*\* Not all topics discussed within the Audio Health Library are covered expenses under your health insurance plan.*

## **GO ONLINE FOR EVEN MORE HEALTH INFORMATION**

If you like to go online for health information, check out the Healthwise<sup>®</sup> Knowledgebase. You can learn more about a health condition you have, medications you take, and more. Link to it through your secure Aetna Navigator<sup>®</sup> website at [www.aetn navigator.com](http://www.aetn navigator.com).

**Health and Wellness Portal:** This dynamic, interactive website will give you health care and assessment tools to calculate body mass index, financial health, risk activities and health and wellness indicators. The site provides resources for wellness programs and activities.

**Beginning Right<sup>SM</sup> Maternity Program:** Give your baby a healthy start. Our Beginning Right Maternity Program comes with your health insurance plan. Use it throughout your pregnancy and after your baby is born. If you have health conditions or risk factors that may need special attention, we can help. Our nurses can give you personal case management to help you find ways to lower your risks. The more you know the better chance you have for good health for you and your baby.

**Aetna Natural Products and Services<sup>SM</sup> Discount Program:** Offers members access to reduced rates on services from natural therapy professionals, including acupuncturists, chiropractors, massage therapists and dietetic counselors, and access to discounts on over-the-counter vitamins, herbal and nutritional supplements and health-related products, such as foot care and natural body care products.

**Quit Tobacco Cessation Program:** Say goodbye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You'll get personal attention from health professionals that can help find what works for you.

**Aetna Health Connections<sup>SM</sup> Disease Management Program:** This program offers support for over 35 conditions with smart technology and supportive services to ensure a healthier you. Our goal is to make it easier to manage your health and live your life well. Our CareEngine<sup>®</sup> system continuously scans your health data to identify safety risks and solutions. Using technology to look for opportunities for better care and programs and services helps to meet your individual needs. You may also receive a call or letter from the Aetna Health Connections Disease Management nurse. Call us at **1-866-269-4500** to get started.

- 24-Hour Telephone Access: You can talk to a licensed mental health professional toll free, 24 hours a day, about any issue. All calls are confidential.
- Interactive Web Resources: With our easy-to-use web resources, you can search for information on relationships, stress, academics, finances, and other issues of special interest . . . comfortably and privately.

Visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) for full program details.

**Vital Savings<sup>SM</sup> on Dental\*** is a dental discount program helping you and your dependents save an average of 15% to 50% on a wide array of dental services. Enroll online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

*\*Actual costs and savings vary by provider and geographic*

**Vital Savings<sup>SM</sup> on Pharmacy** is a discount program helping you and your dependents lower your prescription drug costs. Present your card to participating pharmacies and receive a discount at the time of purchase, no claims to file. Enroll online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

**Vital Savings<sup>SM</sup> on Pharmacy and Dental** is a discount program helping you and your dependents save on prescription drug costs and a wide array of dental services. Enroll online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). Save time and money on enrollment fees by joining both programs in one step.

**Vital Savings on Dental and Pharmacy**

2009/2010	Annual-Dental 9/1/09 – 8/31/10	Annual-Pharmacy 9/1/09 – 8/31/10	Annual-Combo 9/1/09 – 8/31/10
<b>Student Only</b>	\$29	\$29	\$46
<b>Student and One Dependent</b>	\$51	\$51	\$81
<b>Student and Two or more Dependents</b>	\$73	\$73	\$115

*\*The Vital Savings by Aetna<sup>®</sup> program (the “Program”) is not insurance. The Program provides Members with access to discounted fees pursuant to schedules negotiated by Aetna Life Insurance Company for the Vital Savings by Aetna<sup>®</sup> discount program. The Program does not make payments directly to the providers participating in the Program. Each Member is obligated to pay for all services or products but will receive a discount from the providers who have contracted with the Discount Medical Plan Organization to participate in the Program. Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, 1-877-698-4825, is the Discount Medical Plan Organization.*

*All of the above services, programs or benefits may be offered by vendors who are independent contractors and not employees or agents of Aetna.*

*Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts are subject to change without notice. Discount programs may not be available in all states.*

*Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professionals.*

## **GENERAL PROVISIONS**

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### **STATE MANDATED BENEFITS**

The Plan will pay benefits in accordance with any applicable New York State Insurance Law(s).

### **SUBROGATION/REIMBURSEMENT RIGHT OF RECOVERY PROVISION**

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives, from all potentially responsible parties. A "Covered Person" includes for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's injuries or illness or any insurance coverage responsible making such payment, including but not limited to:

- Uninsured motorist coverage,
- Underinsured motorist coverage,
- Personal umbrella coverage,
- Med-pay coverage,
- Workers compensation coverage,
- No-fault automobile insurance coverage, or
- Any other first party insurance coverage

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

## **COORDINATION OF BENEFITS**

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

## **EXTENSION OF BENEFITS**

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If Basic Sickness Expense, coverage for a **covered person** ends while he is **totally disabled**, benefits will continue to be available for expenses incurred for that person only while the **covered person** continues to be **totally disabled**. Benefits will end three months from the date coverage ends. Benefits will continue to be available for a **covered person** who incurs medical expenses directly relating to a pregnancy that began before coverage under this Policy ceased. Such benefits will be covered only for the period of that pregnancy.

If a **covered person** is confined to a **hospital** or under treatment for a covered condition on the date his or her Basic Sickness Expense coverage terminates, charges incurred during the continuation of that hospital confinement or for that treatment of the covered condition shall also be included in the term "Expense", but only while they are incurred during the 90 day period following such termination of insurance.

## **TERMINATION OF INSURANCE**

Benefits are payable under this policy only for those Covered Expenses incurred while the policy is in effect as to the Covered Person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

## **TERMINATION OF STUDENT COVERAGE**

Insurance for a **covered student** will end on the first of these to occur:

- 1) the date this Policy terminates,
- 2) the last day for which any required premium has been paid,
- 3) the date on which the **covered student** withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within 90 days from withdrawal,
- 4) the date the **covered student** is no longer in an eligible class.

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled, and for which premium has been paid.

## **TERMINATION OF DEPENDENT COVERAGE**

Insurance for a **covered student's dependent** will end when insurance for the **covered student** ends. Before then, coverage will end:

- a) For a child, on the first premium due date following the first to occur of:
  - 1) the date the child is no longer chiefly dependent upon the student for support and maintenance,
  - 2) the date of the child's marriage, and
  - 3) the child's 19<sup>th</sup> birthday
- b) The date the **covered student** fails to pay any required premium
- c) For the spouse, the date the marriage ends in divorce or annulment
- d) The date **dependent** coverage is deleted from this Policy
- e) For a domestic partner, the earlier to occur of:
  - 1) the date this Policy no longer allows coverage for domestic partners, and
  - 2) the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Policyholder
- f) The date the **dependent** ceases to be in an eligible class.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

## **INCAPACITATED DEPENDENT CHILDREN**

Insurance may be continued for incapacitated **dependent** children who reach the age at which insurance would otherwise cease. The **dependent** child must be chiefly dependent for support upon the **covered student** and be incapable of self-sustaining employment because of mental or physical handicap.

Due proof of the child's incapacity and dependency must be furnished to Aetna by the **covered student** within 31 days after the date insurance would otherwise cease. Such child will be considered a **covered dependent**, so long as the **covered student** submits proof to Aetna at reasonable intervals during the two (2) years following the child's attainment of the limiting age and each year thereafter, that the child remains physically or mentally unable to earn his own living. The premium due for the child's insurance will be the same as for a child who is not so incapacitated.

The child's insurance under this provision will end on the earlier of:

- 1) the date specified under the provision entitled Termination of Dependent Coverage, or
- 2) the date the child is no longer incapacitated and dependent on the **covered student** for support

## **CONTINUATION OF COVERAGE**

A **covered student** who has graduated or is otherwise ineligible for coverage under this Policy, and has been continuously insured under the plan offered by the Policyholder (regular student plan), may be covered for up to 6 months provided that: 1) a written request for continuation has been forwarded to Aetna 31 days prior to the termination of coverage, and 2) premium payment has been made. Coverage under this provision ceases on the date this Policy terminates.

## **EXCLUSIONS**

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This Policy does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or **Hospital**, or by health care providers employed by the Policyholder.
2. Expense incurred for eye refractions, vision therapy, radial keratotomy (unless medically necessary), eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or **prescriptions** or examinations except as required for repair caused by a covered **injury**.
3. Expense incurred as a result of **injury** due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
4. Aviation. This does not apply if a person is a fare paying passenger or a scheduled charter flight operated by a scheduled airline.
5. Expense incurred as a result of an **injury** or **sickness** due to working for wage or profit or for which benefits are provided under any Workers' Compensation or Occupational Disease Law.
6. Expense incurred as a result of an **injury** sustained or **sickness** contracted while in the service of the Armed Forces of any country. Upon the **covered person** entering the Armed Forces of any country, the unearned pro-rata premium will be refunded to the Policyholder.
7. Expense incurred for treatment provided in a governmental **hospital** unless there is a legal obligation to pay such charges in the absence of insurance.
8. Expense incurred for **elective treatment** or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to:
  - Improve the function of a part of the body that:
    - is not a tooth or structure that supports the teeth, and
    - is malformed:
      - as a result of a severe birth defect, including harelip, webbed fingers, or toes, or
      - as direct result of:
        - disease, or
        - surgery performed to treat a disease or **injury**.

This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Repair of an **injury** (including reconstructive surgery for prosthetic device for a **covered person** who has undergone a mastectomy,) which occurs while the **covered person** is covered under this Policy. Surgery must be performed in the next calendar year.

This exclusion does not apply to reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

10. Expense covered by any other valid and collectible medical, health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.
11. Expense for **injuries** sustained as the result of a motor vehicle accident to the extent that benefits are provided under any mandatory automobile “no fault” coverage.
12. Expense incurred as a result of commission of a felony.
13. Expense incurred after the date insurance terminates for a **covered person** except as may be specifically provided in the Extension of Benefits Provision.
14. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
15. Expense incurred for any services rendered by a member of the **covered person's** immediate family or a person who lives in the **covered person's** home.
16. Expense incurred for a treatment, service, or supply which is not **medically necessary** as determined by Aetna, for the diagnosis care or treatment of the **sickness** or **injury** involved. This applies even if they are prescribed recommended or approved by the person’s attending **physician** or **dentist**.
17. Expense incurred for **injury** resulting from the play or practice of collegiate or intercollegiate sports, including collegiate or intercollegiate club sports and intermurals.
18. Expense incurred by a **covered person** for services performed within the **covered person's** home country (other than the United States, Canada, or Mexico) if the **covered person's** home country has a socialized medicine program.
19. Expense incurred for **custodial care**, except as medically necessary. **Custodial care** means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
  - by whom they are prescribed, or
  - by whom they are recommended, or
  - by whom or by which they are performed

20. Expense incurred for the removal of an organ from a **covered person** for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a **covered person** to a spouse, child, brother, sister, or parent.
21. Expenses incurred for or in connection with: procedures, services, or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or **injury** involved, or
  - If required by the FDA, approval has not been granted for marketing, or
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes, or
  - The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment, and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination, Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status, or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute, or
- Are recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following reference compendia:
  - The American Medical Association Drug Evaluations,
  - The American Hospital Formulary Service Drug Information, or
  - The United States Pharmacopeia Drug Information, or
  - Recommended by review article or editorial comment in a major peer reviewed professional journal, or
  - If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

22. Expense incurred for acupuncture, unless services are rendered for anesthetic purposes.
23. Expense incurred for alternative, holistic medicine, and/or therapy, including but not limited to, yoga and hypnotherapy.
24. Expense for: a) care of flat feet, b) supportive devices for the foot, c) care of corns, bunions, or calluses, d) care of toenails, and e) care of fallen arches, weak feet, or chronic foot strain, except that c) and d) are not excluded when **medically necessary**, because the **covered person** is diabetic, or suffers from circulatory problems.
25. Expense for **injuries** sustained as the result of a motor vehicle **accident**, to the extent that benefits are payable under other valid and collectible insurance, whether or not claim is made for such benefits. The Policy will only pay for those losses, which are not payable under the automobile medical payment insurance Policy.
26. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.
27. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B, even though the **covered person** is eligible, but did not enroll in Part B.
28. Expense for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

29. Expense for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a **physician**.
30. Expense for incidental surgeries, and standby charges of a **physician**.
31. Expense incurred for the use of orthotics, unless used exclusively to promote healing.
32. Expense incurred as a result of **dental** treatment, including extraction of wisdom teeth, except for treatment resulting from **injury to sound natural teeth**, as provided elsewhere in this Policy.
33. Expense for contraceptive methods, devices or aids, and charges for services and supplies for or related to gamete intrafallopian transfer, artificial insemination, in-vitro fertilization (except as required by the state law), or embryo transfer procedures, elective sterilization or its reversal, or elective abortion, unless specifically provided for in this Policy.
34. Expenses incurred for massage therapy.
35. Expense incurred for, or related to, sex change surgery, or to any treatment of gender identity disorder.
36. Expense for charges that are not **recognized charges**, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the **recognized charge** for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.
37. Expense for charges that are not **reasonable charges**, as determined by Aetna, except that this will not apply if the charge for a service, or supply, does not exceed the **reasonable charge** for that service or supply, by more than the amount or percentage, specified as the Allowable Variation.
38. Expense for treatment of **covered students** who specialize in the mental health care field, and who receive treatment as a part of their training in that field.
39. Expenses for treatment of **injury** or **sickness** to the extent payment is made, as a judgment or settlement, by any person deemed responsible for the **injury** or **sickness** (or their Insurers).

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

## DEFINITIONS

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### **Accident**

An occurrence which a) is unforeseen b) is not due to or contributed to by **sickness** or disease of any kind, and c) causes **injury**.

### **Actual Charge**

The charge made for a covered service by the provider who furnishes it.

### **Aggregate Maximum**

The maximum benefit that will be paid under this Policy for all **Covered Medical Expenses** incurred by a covered person that accumulate **from one Policy Year to the next**.

### **Ambulatory Surgical Center**

A freestanding ambulatory surgical facility that:

- Meets licensing standards
- Is set up, equipped and run to provide general surgery
- Makes charges
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period
- Has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period
- Extends surgical staff privileges to:
  - physicians who practice surgery in an area **hospital**, and

- **dentists** who perform oral surgery
- Has at least 2 operating rooms and one recovery room
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery
- Does not have a place for patients to stay overnight
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle medical emergencies  
It must have:
  - a physician trained in cardiopulmonary resuscitation, and
  - a defibrillator, and
  - a tracheotomy set, and
  - a blood volume expander
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient

### **Birthing Center**

A freestanding facility that:

- Meets licensing standards
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care
- Makes charges
- Is directed by at least one physician who is a specialist in obstetrics and gynecology
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area **hospital**
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a R.N. or certified nurse midwife
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor and if a child is born with an abnormality which impairs function or threatens life
- Accepts only patients with low risk pregnancies
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility
- Keeps a medical record on each patient and child

### **Brand Name Prescription Drug or Medicine**

A **prescription drug** which is protected by trademark registration.

### **Complications of Pregnancy**

Conditions which require **hospital** stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis, or
- cardiac decompensation or missed abortion, or
- similar conditions as severe as these

Not included are a) false labor, occasional spotting or **physician** prescribed rest during the period of pregnancy, b) morning **sickness**, c) hyperemesis gravidarum and preclampsia, and d) similar conditions not medically distinct from a difficult pregnancy.

**Complications of Pregnancy** also include:

- non-elective cesarean section, and
- termination of an ectopic pregnancy, and
- spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

### **Copay**

This is a fee charged to a person for **Covered Medical Expenses**. For Prescribed Medicines Expense, the **copay** is payable directly to the **pharmacy** for each: **prescription**, kit, or refill, at the time it is dispensed. In no event will the **copay** be greater than the **pharmacy's** charge per: **prescription**, kit, or refill.

### **Covered dependent**

A **covered student's dependent** who is insured under this Policy.

### **Covered Medical Expense**

Those charges for any treatment, service or supplies covered by this Policy which are:

- not in excess of the **reasonable and customary** charges, or
- not in excess of the charges that would have been made in the absence of this coverage, and
- incurred while this Policy is in force as to the **covered person** except with respect to any expenses payable under the Extension of Benefit Provisions.

### **Covered person**

A **covered student** and any **covered dependent** while coverage under this Policy is in effect.

### **Covered student**

A student of the Policyholder who is insured under this Policy.

### **Deductible**

The amount of **Covered Medical Expenses** that are paid by each **covered person** during the **policy year** before benefits are paid.

### **Dependent**

a) the **covered student's** spouse residing with the **covered student**, or b) the person identified as a domestic partner in the "Declaration of Domestic Partnership" which is completed and signed by the **covered student**, and c) the **covered student's** unmarried child under the age of 19 years. The child must reside with, and be fully supported by, the **covered student**.

The term "child" includes a **covered student's** step-child, adopted child whose coverage is effective upon the earlier of the date of placement for the purpose of adoption, or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption and who is residing with the covered student, and who is chiefly dependent on the **covered student** for his or her full support.

The term **dependent** does not include a person who is: (a) an eligible student, or (b) a member of the armed forces.

### **Designated Care**

Care provided by a **Designated Care Provider** upon referral from the **School Health Services**.

### **Designated Care Provider**

A health care provider [or **pharmacy**] that is affiliated with, and has an agreement with, the **School Health Services** to furnish services and supplies at a **negotiated charge**.

### **Diabetic Self-Management Education**

Training designed to instruct a person in the self-management of diabetes. It may include training in self-care or diet. If a physician, nurse practitioner or clinical nurse specialist diagnoses diabetes, or diagnoses a significant change in the person's diabetic symptoms, or condition that requires a change in the person's self-management of the disease or determines that a person who is a diabetic needs re-education, or refresher education, this diabetic self-management education may be provided by the physician or other licensed health care provider legally qualified by the State of New York to provide diabetic management education, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon the referral of a physician, or other licensed health care provider legally qualified by the State of New York to provide diabetic management education. When diabetic self-management education is provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a physician, such education may be provided in a group setting. When medically necessary, diabetic self-management education shall also include home visits.

### **Directory**

A listing of **Preferred Care Providers** in the **service area** covered under this Policy, which is given to the Policyholder.

### **Elective Treatment**

Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the **covered person's** effective date of coverage. **Elective treatment** includes, but is not limited to:

- tubal ligation,
- vasectomy,
- breast reduction,
- sexual reassignment surgery,
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis,
- treatment for weight reduction,
- learning disabilities,
- temporomandibular joint dysfunction (TMJ),
- immunization,
- treatment of infertility, and
- routine physical examinations

### **Emergency Admission**

One where the **physician** admits the person to the **hospital** or **residential treatment facility** right after the sudden and at that time, unexpected onset of a change in a person's medical or behavioral condition which:

- requires confinement right away as a full-time inpatient, and
- manifests itself by symptoms of sufficient severity, including severe pain, that if immediate medical attention was not given could, as determined by a prudent lay person possessing an average knowledge of medicine and health, reasonably be expected to result in:
  - 1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy,
  - 2) serious impairment to such person's bodily functions,
  - 3) serious dysfunction of any bodily organ or part of such person, or
  - 4) serious disfigurement of such person

### **Emergency Medical Condition**

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- 1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy,
- 2) serious impairment to such person's bodily functions,
- 3) serious dysfunction of any bodily organ or part of such person, or
- 4) serious disfigurement of such person

### **Generic Prescription Drug or Medicine**

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

### **Home Health Agency**

- an agency licensed as a **home health agency** by the state in which **home health care** services are provided, or
- an agency certified as such under Medicare, or
- an agency approved as such by Aetna

### **Home health aide**

A certified or trained professional who provides services through a **home health agency** which are not required to be performed by an RN, LPN, or LVN, primarily to aid the **covered person** in performing the normal activities of daily living while recovering from an **injury** or **sickness**, and are described under the written **Home Health Care Plan**.

### **Home Health Care**

Health services and supplies provided to a **covered person** on a part-time, intermittent, visiting basis. Such services and supplies must be provided in such person's place of residence, while the person is confined as a result of **injury** or **sickness**. A **physician** must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a **hospital** or **skilled facility**, and the services must be furnished by, or under arrangements made by, a licensed home health agency.

### **Home Health Care Plan**

A written plan of care established and approved in writing by a physician, for continued health care and treatment in a covered person's home. It must follow within 7 days of discharge and be for the same or related cause(s) as a period of hospital or skilled nursing confinement. The physician must examine the covered person at least once a month, and the physician must renew the written plan every 60 days.

### **Home Health Care Services**

- Part-time or intermittent nursing care by: a registered nurse (R. N.), a licensed Practical nurse (L.P.N.), or under the supervision on an R.N. if the services of an R. N. are not available,
- Part time or intermittent home health aide services, that consist primarily of care of a medical or therapeutic nature by other than an R.N.,
- Physical, occupational. speech therapy, or respiratory therapy,
- Medical supplies, drugs and medicines, and laboratory services. However, these items are covered only to the extent they would be covered if the patient was confined to a hospital,
- Medical social services by licensed or trained social workers,
- Nutritional counseling.

### **Hospice**

A facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors, and volunteers. The team acts under an independent **hospice** administration and it helps the patient cope with physical, psychological, spiritual, social, and economic stresses. The hospital administration must meet the standards of the National Hospice Organization and any licensing requirements.

### **Hospice benefit period**

A period that begins on the date the attending **physician** certifies that the **covered person** is a terminally ill patient who has less than 6 months to live. It ends after 6 months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

### **Hospital**

A facility which meets all of these tests:

- it provides in-patient services for the case and treatment of injured and sick people, and
- it provides room and board services and nursing services 24 hours a day, and
- it has established facilities for diagnosis and major surgery, and
- it is run as a **hospital** under the laws of the jurisdiction which it is located.

**Hospital** does not include a place run mainly: a) for alcoholics or drug addicts, b) as a convalescent home, or c) as a nursing or rest home. The term “**hospital**” includes an alcohol and drug addiction treatment facility during any period in which it provides effective treatment of alcohol and drug addiction to the **covered person**.

### **Hospital Confinement**

A documented inpatient stay in a **hospital** as a resident bed patient.

### **Injury**

Bodily **injury** caused by an **accident**. This includes related conditions and recurrent symptoms of such **injury**.

### **Intensive Care Unit**

A designated ward, unit, or area within a **hospital** for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services, not regularly provided within such **hospital**.

### **Mail Order Pharmacy**

[An establishment where **prescription drugs** are legally dispensed by mail.

### **Medically Necessary**

A service or supply that is necessary and appropriate for the diagnosis or treatment of a **sickness** or **injury** based on generally accepted current medical practice. A service or supply will not be considered as **medically necessary** if:

- It is provided only as a convenience to the **covered person** or provider, or
- it is not the appropriate treatment for the **covered person**'s diagnosis or symptoms, or
- it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular **physician** may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

### **Medication Formulary**

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists, for their therapeutic equivalency and efficacy. This listing includes both brand name and **generic prescription drugs**. This listing is subject to periodic review, and modification by Aetna.

### **Negotiated Charge**

The maximum charge a **Preferred Care Provider** or **Designated Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Policy.

### **Non-Preferred Care**

A health care service or supply furnished by a health care provider that is not a **Designated Care Provider**, or that is not a **Preferred Care Provider**, if, as determined by Aetna:

- the service or supply could have been provided by a Preferred Care Provider, and
- the provider is of a type that falls into one or more of the categories of providers listed in the directory.

### **Non-Preferred Care Provider**

- a health care provider that has not contracted to furnish services or supplies at a **negotiated charge**, or
- a **Preferred Care Provider** that is furnishing services or supplies without the referral of a **School Health Services**.

**Non-Preferred Pharmacy**

A **pharmacy** not party to a contract with Aetna, or a **pharmacy** who is party to such a contract but who does not dispense **prescription drugs** in accordance with its terms.

**Non-Preferred Prescription Drug Expense**

An expense incurred for a **prescription drug** that is not a **preferred prescription drug expense**.

**One Sickness**

A **sickness** and all recurrences and related conditions which are sustained by a **covered person**.

**Orthodontic treatment**

Any:

- medical service or supply, or
- dental service or supply,

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth, or
- of the bite, or
- of the jaws or jaw joint relationship,

whether or not for the purpose of relieving pain. Not included is:

- the installation of a space maintainer, or
- surgical procedure to correct malocclusion.

**Partial hospitalization**

Continuous treatment consisting of not less than four hours and not more than twelve hours in any twenty-four hour period under a program based in a **hospital**.

**Pharmacy**

An establishment where **prescription drugs** are legally dispensed.

**Physician**

a) legally qualified **physician** licensed by the state in which he or she practices, and b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

**Policy Year**

The period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

**Pre-Existing Condition**

Any **injury, sickness**, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six months prior to the **covered person's** enrollment date.

For purposes of this definition, "enrollment date" means the covered person's effective date of insurance or, if earlier, the first day of any applicable waiting period.

**Preferred Care**

Care provided by:

- a covered person's primary care physician, or a preferred care provider of the primary care **physician**, or
- a health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, is not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

### **Preferred Care Provider**

A health care provider that has contracted to furnish services or supplies for a **negotiated charge**, but only if the provider is, with Aetna's consent, included in the **directory** as a **Preferred Care Provider** for:

- the service or supply involved, and
- the class of **covered persons** of which you are member.

### **Preferred Pharmacy**

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:

- while the contract remains in effect, and
- while such a **pharmacy** dispenses a **prescription drug**, under the terms of its contract with Aetna.

### **Preferred Prescription Drug Expense**

An expense incurred for a **prescription drug** that:

- is dispensed by a Preferred Pharmacy, or for an emergency medical condition only, by a non-preferred pharmacy, and
- is dispensed upon the **Prescription** of a **Prescriber** who is:
  - a **Designated Care Provider**, or
  - a **Preferred Care Provider**, or
  - a **Non-Preferred Care Provider**, but only for an **emergency condition** of a person's **Primary Care Physician**, or
  - a **dentist** who is a **Non-Preferred Care Provider**, but only one who is not of a type that falls into one or more of the categories of providers listed in the **directory** of **Preferred Care Providers**.

### **Prescriber**

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

### **Prescription**

An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.

### **Prescription Drugs**

Any of the following:

- A drug, biological, or compounded **prescription**, which, by Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without **prescription**",
- Injectable insulin, disposable needles, and syringes, when prescribed and purchased at the same time as insulin, and disposable diabetic supplies.

### **Primary Care Physician**

This is the Preferred Care Provider who is:

- selected by a person from the list of **Primary Care Physicians** in the **directory**,
- responsible for the person's on-going health care, and
- shown on Aetna's records as the person's **Primary Care Physician**.

For purposes of this definition, a **Primary Care Physician** also includes the **School Health Services**.

### **Reasonable Charge**

Only that part of a charge which is reasonable is covered. The **reasonable charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the **reasonable charge** is the rate established in such agreement.

In determining the **reasonable charge** for a service or supply that is:

- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area

Aetna may take into account factors, such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and
- The prevailing charge in other areas.

### **Residential treatment facility**

A treatment center for children and adolescents, which provides residential care and treatment for emotionally disturbed individuals, and is licensed by the department of children and youth services, and is accredited as a residential treatment center by the council on accreditation or the joint commission on accreditation of health organizations.

### **Respite care**

Care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill **covered person**.

### **Room and Board**

Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

### **School Health Services**

Any organization, facility, or clinic operated, maintained, or supported by the school or other entity under contract to the school which provides health care services to enrolled students and their **dependents**.

### **Semi-private Rate**

The charge for **room and board** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

### **Service Area**

The geographic area, as determined by Aetna, in which the **Preferred Care Providers** are located.

### **Sickness**

Disease or illness including related conditions and recurrent symptoms of the **sickness**. **Sickness** also includes pregnancy, and **complications** of **pregnancy**. All **injuries** or **sickness** due to the same or a related cause are considered one **injury** or **sickness**.

### **Skilled Nursing Facility**

A lawfully operating institution engaged mainly in providing treatment for people convalescing from **injury** or **sickness**. It must have:

- organized facilities for medical services,
- 24 hours nursing service by RNs,
- a capacity of six or more beds,
- a daily medical records for each patient, and
- a **physician** available at all times.

### **Sound Natural Teeth**

Natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. **Sound natural teeth** shall not include capped teeth.

**Surgical assistant**

A medical professional trained to assist in surgery in both the preoperative and postoperative periods under the supervision of a **physician**.

**Surgical expense**

Charges by a **physician** for,

- a surgical procedure,
- a necessary preoperative treatment during a **hospital** stay in connection with such procedure, and
- usual postoperative treatment.

**Surgical procedure**

- a cutting procedure,
- suturing of a wound,
- treatment of a fracture,
- reduction of a dislocation,
- radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor,
- electrocauterization,
- diagnostic and therapeutic endoscopic procedures,
- injection treatment of hemorrhoids and varicose veins,
- an operation by means of laser beam,
- cryosurgery

**Totally Disabled**

Due to disease or **injury**, the **covered person** is not able to engage in most of the normal activities of a person of like age and sex in good health.

**Urgent Admission**

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease, or
- the diagnosis of a disease, or
- an **injury** caused by an **accident**,

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

**Urgent Condition**

This means a sudden illness, **injury**, or condition, that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the **covered person's** health,
- includes a condition which would subject the **covered person** to severe pain that could not be adequately managed without urgent care or treatment,
- does not require the level of care provided in the emergency room of a **hospital**, and
- requires immediate outpatient medical care that cannot be postponed until the **covered person's physician** becomes reasonably available.

### **Urgent Care Provider**

This is:

- A freestanding medical facility which:
  - Provides unscheduled medical services to treat an **urgent condition** if the **covered person's physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one such **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician's** office, but only one that:
  - has contracted with Aetna to provide urgent care, and
  - is, with Aetna's consent, included in the Provider **Directory** as a Preferred Urgent Care Provider.

**It is not the emergency room or outpatient department of a hospital.**

### **Walk-in Clinic**

A clinic with a group of **physicians**, which is not affiliated with a **hospital**, that provides: diagnostic services, observation, treatment, and rehabilitation on an outpatient basis.

## **CLAIM PROCEDURE**

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On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by Aetna.

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday, ET for any questions.

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or physician concerned, unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. You will receive an "Explanation of Benefits" when your claims are processed. The Explanation of Benefits will explain how your claim was processed, according to the benefits of your Student Accident and Sickness Insurance Plan.

### **HOW TO APPEAL A CLAIM**

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person's request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician's office notes, operative reports, Physician's letter of medical necessity, etc.). Please submit all requests to:

Aetna Student Health  
P.O. Box 15717  
Boston, MA 02215-0014

## INTERNAL APPEALS PROCEDURE

Aetna has established a procedure for resolving appeals by **covered persons**. If the **covered person** has an appeal, please follow this procedure:

- An Appeal is defined as a written request for review of a decision that has been denied in whole or in part, after consideration of any relevant information, a request for: claim payment, certification, eligibility, referral, etc.

### First Level Appeals Procedure

- An Appeal must be submitted to Aetna within 180 days of the date Aetna provides notice of denial. The Aetna address is on the **covered person's** ID card. The Appeal may be submitted by the **covered person**, or by a representative, designated by the **covered person**.
- The **covered person** may submit an oral grievance in connection with:
  - A denial of, or failure to pay for, a referral, or
  - A determination as to whether a benefit is covered under this Plan, by calling Member Services. Aetna's Member Services telephone number is on the **covered person's** ID card. If the **covered person** is required to leave a recorded message, the **covered person's** message will be acknowledged within one business day after the call was recorded.

Aetna will summarize the nature of the grievance in writing. The **covered person** will be required to sign a written acknowledgement of the grievance. Such acknowledgement will be mailed promptly to the **covered person**. The **covered person** must sign and return the acknowledgement, with any amendments, in order to initiate the grievance. Upon receipt of the signed acknowledgement, the process below will be followed.

- An acknowledgment letter will be sent to the **covered person** within 1 day of Aetna's receipt of an oral Appeal, and 5 days of Aetna's receipt of a written Appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- The **covered person** will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with, or subsequent to, the Appeal.
- If the Appeal concerns an eligibility issue, and if additional information is not submitted to Aetna after receipt of Aetna's response, the decision is considered Aetna's final response, 45 days after receipt of the Appeal. For all other Appeals, if additional information is to be submitted to Aetna after receipt of Aetna's response, it must be submitted within 15 days of the date of Aetna's response letter.
- Aetna's response will be sent within 30 days from the date of Aetna's first response letter.

In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on the **covered person's** ID card. A verbal response to the Appeal will be given to the **covered person** and **covered person's** provider within 2 days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response.

### Second Level Appeals Procedure

If the **covered person** is dissatisfied with Aetna's grievance determination, the **covered person**, or a representative designated by the **covered person**, may submit a written appeal within 60 business days after receipt of such determination.

- An acknowledgement letter will be sent to the **covered person** within 15 days of Aetna's receipt of the written appeal. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.
- Aetna's final response for an urgent or emergency situation will be sent within 2 business days. For all other situations, a response will be sent within 30 business days from the date of Aetna's receipt of all necessary information.

If additional time is needed to resolve an Appeal, except in an urgent or emergency situation, Aetna will provide a written notification, indicating that additional time is needed, explaining why such time is needed, and setting a new date for a response. The additional time will not be extended beyond another 30 days.

The **covered person** must exhaust the Internal Appeals Procedure before requesting an External Appeal. However, the **covered person** is not required to exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if the **covered person** and Aetna have agreed that the matter may proceed directly to an External Appeal.

Aetna will keep the records of the **covered persons** complaint for 3 years.

## **External Review Process**

### **EXTERNAL APPEAL**

#### **RIGHT TO AN EXTERNAL APPEAL**

Under certain circumstances, the **covered person** has a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **covered person** may appeal that decision to an External Appeal Agent, an independent entity certified by the State, to conduct such appeals.

#### **RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT NECESSARY**

If Aetna has denied coverage on the basis that the service is not necessary, the **covered person** may appeal to an External Appeal Agent, if the **covered person** satisfies the following criteria listed below:

- The service, procedure, or treatment, must otherwise be a Covered Medical Expense under this Plan, and
- The **covered person** must have received a final adverse determination through the first level of Aetna's internal review process, and Aetna must have upheld the denial, or the **covered person** and Aetna must agree in writing, to waive any internal appeal.

#### **RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL**

If the **covered person** has been denied coverage on the basis that the service is an experimental or investigational treatment, the **covered person** must satisfy the following criteria:

- The service must otherwise be a Covered Medical Expense under this Plan, and
- The **covered person** must have received a final adverse determination through the first level of Aetna's internal appeal process, and Aetna must have upheld the denial, or the **covered person** and Aetna must agree in writing to waive any internal appeal.

In addition, the **covered person's** attending physician must certify that the **covered person** has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted, or can be expected to last, for a continuous period of not less than 12 months, which renders the **covered person** unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The **covered person's** attending physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective, or medically inappropriate, or one for which there does not exist a more beneficial standard service or procedure covered under this Plan, or one for which there exists a clinical trial (as defined by law).

In addition, the **covered persons** attending physician must have recommended at least one of the following:

- A service, procedure or treatment that 2 documents from available medical and scientific evidence indicate is likely to be more beneficial to the **covered person** than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – the **covered person's** attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable), or

- A clinical trial for which the **covered person** is eligible (only certain clinical trials can be considered).

For the purposes of this section, the **covered person's** attending physician must be a licensed, board certified, or board eligible physician, qualified to practice in the area appropriate to treat the **covered person's** life-threatening or disabling condition or disease.

## THE EXTERNAL APPEAL PROCESS

If, through the Aetna's internal appeal process, the **covered person** has received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary, or is an experimental or investigational treatment, the **covered person** has 45 days from receipt of such notice to file a written request for an external appeal. If the **covered person** and Aetna have agreed to waive any internal appeal, the **covered person** has 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse determination issued through the Aetna's internal appeal process or its written waiver of an internal appeal.

The **covered person** may also request an external appeal application from the New York State Department of Insurance at **1-800-400-8882**. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If the **covered person** satisfies the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The **covered person** will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information the **covered person** submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have 3 business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The External Appeal Agent may request additional information from the **covered person**, the **covered person's** physician or Aetna. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify the **covered person** in writing of its decision within 2 business days.

If the **covered person's** attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the **covered person's** health, the **covered person** may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 3 days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the **covered person** and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify the **covered person** in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not necessary, or approves coverage of an experimental or investigational treatment, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to the **covered person** according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the **covered person** and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

The **covered person** will be charged a fee of \$50 for an external appeal. The external appeal application will instruct the **covered person** on the manner in which the **covered person** must submit the fee. Aetna will also waive the fee if Aetna determines that paying the fee would pose a hardship to the **covered person**. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to the **covered person**.

## RESPONSIBILITIES

It is the **covered person's** responsibility to initiate the external appeals process. The **covered person** may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to the **covered person**, the **covered person's** attending physician may file an expedited appeal application on the **covered person's** behalf, but only if the **covered person** has consented to this in writing.

Under New York State law, the **covered person's** completed request for appeal must be filed within 45 days of either the date upon which the **covered person** receives written notification from Aetna that it has upheld a denial of coverage, or the date upon which the **covered person** receives a written waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

## COVERED SERVICES AND EXCLUSIONS

In general, this Plan does not cover experimental or investigational treatments. However, this Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to **the covered person**, according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

## PRESCRIPTION DRUG CLAIM PROCEDURE

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When obtaining a covered Prescription, please present your Aetna ID card to the Pharmacy.

To be reimbursed for your prescription, submit a completed Aetna Prescription Drug claim form. A claim form is available by calling **800-238-6279**, **visiting University Health Plans at [www.universityhealthplans.com](http://www.universityhealthplans.com)**, or by **visiting [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)**. You will be reimbursed for covered medications directly by Aetna.

Claim forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **800-238-6279**.

When submitting a claim, please include all Prescription receipts, indicate that you attend RIT and include your name, address, and student identification number.

## On Call International

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Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency travel assistance services and other benefits. A brief description of these benefits is outlined below.

### Accidental Death and Dismemberment (ADD) Benefits

**Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of Ten Thousand Dollars (\$10,000).**

**NOTE: For most school plans, ADD benefits are provided by Aetna Life Insurance Company (ALIC). However, in some states, ADD benefits may be provided through a contractual relationship between Chickering Claims Administrators, Inc. (CCA) and On Call International (On Call). ADD coverage provided through On Call is underwritten by United States Fire Insurance Company (USFIC). Please refer to your school's policy to determine whether ALIC or USFIC underwrites ADD benefits for your specific Plan. Should you have questions or need to file a claim please contact 800-466-3185.**

## **MEDICAL EVACUATION AND REPATRIATION (MER) AND WORLDWIDE EMERGENCY TRAVEL ASSISTANCE (WETA) SERVICES PROVIDED THROUGH ON CALL INTERNATIONAL, INC.**

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International, Inc. (On Call) to provide Covered Persons with access to certain Medical Evacuation and Repatriation (MER) and Worldwide Emergency Travel Assistance (WETA) benefits and/or services.

**Medical Evacuation and Repatriation (MER) Benefits.** The following benefits are underwritten by Virginia Surety Company (VSC), with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation (while traveling or on campus)
- Unlimited Return of Mortal Remains (while traveling or on campus)
- Return of Traveling Companion
- 2,500 Emergency Return Home in the event of death or life-threatening illness of a parent or sibling

**Worldwide Emergency Travel Assistance (WETA) Services.** On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- 24/7 U.S. Nurse Help Line
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance

**NOTE: In order to obtain coverage, all MER and WETA services must be provided and arranged through On Call. Reimbursement will NOT be provided for any such services not provided and arranged through On Call. Although certain medical services may be covered under the terms of the Covered Person's student health insurance plan (the "Plan"), On Call does not provide coverage for medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions and limitations may apply.**

**To obtain MER and WETA benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free 1-866-525-1956 or collect 1-603-328-1956. All Covered Persons should carry their On Call ID cards when traveling.**

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to certain ADD, MER and WETA benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates underwrites or administers any MER or WETA benefits/services. Neither CCA nor any of its affiliates underwrites or administers any ADD benefits that are provided through On Call. Neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC or VSC. Premiums/fees for benefits/services provided through On Call, USFIC and VSC are included in the Rates outlined in this brochure.

### **Got Questions? Get Answers with Aetna's Navigator®**

As an Aetna Student Health insurance member, you have access to Aetna Navigator®, your secure member website, packed with personalized claims and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online. **By logging into Aetna Navigator, you can:**

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Aetna Student Health Customer Service at your convenience.
- View the latest health information and news, and more!

### **How do I register?**

- Go to **[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)**
- Find your school in the School Directory
- Click on Aetna Navigator® Member Website and then the “Register for Aetna Navigator” link.
- Follow the instructions for the registration process, including selecting a user name, password and security phrase.

### **Need help with registering onto Aetna Navigator?**

Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at **(800) 225-3375**.

## NOTICE

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

### **Administered by:**

Aetna Student Health.  
P.O. Box 15708  
Boston, MA 02215-0014



[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

### **Underwritten by:**

Aetna Life Insurance Company (ALIC)  
151 Farmington Avenue  
Hartford, CT 06156  
**(860) 273-0123**

Policy No. 812809

The Rochester Institute of Technology Student Accident and Sickness Plan is underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by these companies and their applicable affiliated companies.

*Notes:*

*[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)*

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